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Incorporating Quality Measures in Health Insurance Exchange Ratings of Health Plans

Maureen Michael, M.G.A.
Dorothy Gaboda, M.S.W., Ph.D.

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Executive Summary

The Patient Protection and Affordable Care Act (ACA) envisions health insurance exchanges as the cornerstone of an improved health care marketplace. Each state-based health exchange Web portal must present comparative quality and cost information. Data are required for each plan on activities to: improve health outcomes, prevent hospital readmissions, improve patient safety and reduce medical errors, and promote health.

While the Secretary of Health and Human Services has not issued final guidance on how exchanges should present such quality information, existing federal quality measurement efforts offer direction on how plan ratings will likely need to be developed. Among those quality measurement programs described in this Issue Brief are: the National Strategy for Quality Improvement in Health Care, the Medicare Advantage Five-Star Quality Rating System, core quality measures for the Children's Health Insurance Program (CHIP) and Medicaid, National Committee for Quality Assurance accreditation, and federal and state report cards.

Some states that are further along in their health exchange development work offer examples of how quality measures might be incorporated into health exchange ratings of plans.

Policy experts interviewed for this report and briefs—including those from the National Committee for Quality Assurance, New Jersey Health Insurance Stakeholder Forums, and the Informed Patient Institute—have provided a range of specific recommendations on the kind of information consumers may want as health insurance purchasers and the format that exchange quality ratings might take.

The information and recommendations presented in this Issue Brief provide a context for decision-makers as they move forward with the planning and design of a New Jersey health insurance exchange that not just meets the ACA quality measurement reporting requirements but assists consumers in making informed health insurance choices.

Incorporating Quality Measures in Health Insurance Exchange Ratings of Health Plans

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Introduction

This Issue Brief outlines considerations for quality measures that might be incorporated into a New Jersey Health Insurance Exchange. The Patient Protection and Affordable Care Act (ACA) envisions exchanges as promoting an efficient and effective health insurance marketplace. A critical component of this marketplace is appropriate information to help consumers and employers with the insurance "shopping" experience, including relevant details about the quality and value associated with various insurance plans. Under the ACA, exchanges are required to provide consumers with quality ratings on health plan choices. These ratings are to be developed in accordance with guidance issued by the Secretary of Health and Human Services (HHS).[1] In part, awaiting final guidance, many states are still in the early planning phases of deciding which measures to incorporate into their exchanges. With that in mind, to help provide context for future decision-making, this report provides a brief overview of some recent federal quality measurement efforts, highlights from measures states have made available to date—especially those states further along in their exchange planning—along with some key considerations for selecting such measures.

Policy and Legal Context

State health insurance exchanges will serve as the cornerstones of an improved health insurance marketplace under the ACA. The law includes a series of data requirements that foster informed decision-making by both individuals and employers.

Quality Information Requirements Under the ACA

The ACA specifies reporting requirements for both the exchange and the qualified health plans to help ensure the quality of insurance plans and informed consumer decision-making with respect to those plans.

[1] *See* http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html.

- *The ACA calls for quality information to be incorporated into the exchange portal.* The ACA requires quality information on each qualified plan to be part of the health exchange website portal. This information is to include a rating of relative quality and price assigned to plans in each benefit level based on criteria developed by the Secretary of Health and Human Services. This is part of a package of standardized information "to assist consumers in making easy health insurance choices." [2] The law requires the portal to include results from enrollee satisfaction surveys also to be developed by the HHS Secretary.

The law also includes a series of plan reporting requirements that could feed into the exchange's quality oversight and information-sharing responsibilities.

- *Qualified plans sold through the exchange are required to broadly report quality performance information.* The ACA requires qualified health plans to report to the exchange, enrollees, and prospective enrollees any quality measures that are required by the HHS Secretary. This information will be tailored to meet the needs of various health care stakeholders—including consumers—and must include, where possible, information on clinical conditions that is, where appropriate "provider-specific and sufficiently disaggregated and specific to meet the needs of patients with different clinical conditions."[3] This information will likely align with the National Strategy for Quality Improvement in Health Care outlined below.
- *All plans will provide their enrollees with information certifying that their benefits and reimbursement strategies are focused on improving quality.* The ACA requires *all* plans (not just qualified plans sold through the exchange) to report information to enrollees during open enrollment periods that helps demonstrate whether the plan's benefits and health care provider reimbursement structures do the following: (1) "improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including the use of medical homes"; (2) "implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional"; (3) "implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence

[2] 42 U.S.C. 18031(c)(5); *see also* Seton Hall University Quality Reporting Requirements Background Paper, "The ACA's Quality, Cost Effectiveness and Care Management Reporting Requirements," June 2011.
[3] 42 U.S.C. § 280j-2(a) and (b).

based medicine, and health information technology; and (4) "implement wellness and health promotion activities."[4]

Guidance From HHS Indicates More Forthcoming on Quality Measures

HHS's Initial Exchange Guidance indicated that whatever model exchange is adopted by states, "states should provide comparison shopping tools that promote choice based on price and quality and enable consumers to narrow plan options based on their preferences."[5]

Proposed regulations related to exchange development clearly indicate the exchanges will be responsible for implementing activities related to quality ratings, but that additional guidance will be forthcoming on how plans will be rated, specifically:

> "The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting pursuant to sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act. We anticipate future rulemaking on these topics, but propose here the basic requirement that the Exchange will have a role in the implementation, oversight, and improvement of the quality and enrollee satisfaction initiatives required by the Affordable Care Act. This will include requirements for quality data collection, standards for assessing a QHP [qualified health plan] issuer's quality improvement strategies, and details on how Exchanges can assess and calculate ratings of health care quality and outcomes using methodologies made available by HHS or alternatives, if applicable."[6]

Federal Quality Measurement Efforts

Among experts, there is a range of opinion on the shape that the forthcoming rating guidance will take. While some believe it will be very nonprescriptive, others believe quality ratings may not stray far from existing plan accreditation criteria. Still others believe that Medicare's Five-Star Quality Rating System likely will be a starting point for any ratings plan developed.[7]

While awaiting further guidance, below are highlights from recent federal quality measurement efforts, including the initial report on the National Strategy for Quality Improvement in Health Care, Medicare Advantage's Five-Star Quality Rating System, efforts to create core quality measures for Children's Health Insurance Program (CHIP) and Medicaid, as

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[4] 42 U.S.C. § 300gg-17(a). The "wellness and health promotion activities" referred to are described in detail at 42 U.S.C. § 300gg-17(b).

[5] Initial Guidance to States on Health Insurance Exchanges.

[6] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Federal Register, Vol. 76, No. 136, Friday, July 15, 2011.

[7] Based on background expert interviews.

well as National Committee for Quality Assurance accreditation and state report card programs.[8]

National Strategy for Quality Improvement in Health Care

The ACA's requirement for the Secretary of HHS to develop a national strategy to improve health care quality calls for creation of goals and benchmarks and "utilization of common quality measures, where available."[9] The strategy must identify priorities for improvement and set forth a comprehensive strategic plan for achieving them [42 U.S.C. § 280j (a) and (b)]. To help formulate the strategy, the Secretary contracted with the National Quality Forum to convene a National Priorities Partnership of 28 national stakeholder organizations that would recommend areas for quality improvement.[10]

The initial report to Congress on the strategy from March 2011 calls for "consistent, nationally endorsed measures," but notes that such metrics are still under development.

In the interim, the strategy report outlines three broad aims—1) better care, 2) improved individual and community health, and 3) more affordable care. It also includes priorities related to these aims and *illustrative* measures of success listed below (see Appendix A for full listing):

- Safer Care—with success measured by reducing hospital-acquired infections and reducing adverse medication events
- Effective Care Coordination—with success measured by reducing readmissions and the share of providers providing a summary record of care for transitions and referrals (while not included in the strategy, other National Quality Forum Care Coordination Measures can be found in Appendix B)
- Person- and Family-Centered Care—with success centered around shared decision-making as measured by the percent of patients asked for feedback
- Prevention and Treatment of Leading Causes of Mortality (starting with cardiovascular disease)—with success measured by blood pressure control, cholesterol management, and use of aspirin/antithrombotics
- Supporting Better Health in Communities—with success measured by children and adults screened for depression and receiving a follow-up plan, share of adults receiving screening and brief intervention for alcohol use, share of people using oral health care, and the share of population with optimally fluoridated water

[8] Based on background expert interviews.
[9] 42 U.S.C. 280j (b) (2) (A).
[10] "Input to the Secretary of Health and Human Services on Priorities for the 2011 National Quality Strategy," National Priorities Partnership, October 2010.

- Making Care More Affordable—with success centered on building cost measurement into payment reforms and tracking success, reducing administrative costs, and increasing cost transparency to consumers (with illustrative measures to be developed)[11]

The ACA provides for $75 million for each of fiscal years 2010 through 2014 to develop quality measures where none exist or where existing measures need improvement, consistent with the National Strategy for Quality.[12] Here, priority is given to measures to assess: "(A) health outcomes and functional status of patients; (B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans; (C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to inform decision-making about treatment options, including the use of shared decision-making tools and preference sensitive care (as defined in section 936); (D) the meaningful use of health information technology; (E) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care; (F) the efficiency of care; (G) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas; (H) patient experience and satisfaction; (I) the use of innovative strategies and methodologies identified under section 933; and (J) other areas determined appropriate by the Secretary."

The Medicare Advantage Five-Star Quality Rating System

The Medicare Advantage plan star rating system is designed to help ensure that Medicare health and drug plans are providing quality care and to allow consumers to compare quality among these plans. Plans earn between one and five stars, designating poor to excellent performance. These stars will assume an increasingly important role in rewarding quality under the ACA, with those Medicare Advantage plans earning ratings of three stars or more receiving higher bonus payments.[13] Plans with lower star ratings are flagged with warnings to consumers.[14]

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[11] "National Strategy for Quality Improvement in Health Care," Department of Health and Human Services Report to Congress, March 2011.

[12] 42 U.S.C. § 299b-31.

[13] Centers for Medicare & Medicaid Services Fact Sheet, "Proposed Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs for Contract Year 2012 and Demonstration on Quality Bonus Payments."
Kaiser Family Foundation Issue Brief, "Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011," February 2011.
Jaffe S. "Rating System for Medicare Advantage Plans is Flawed; Changes Are Planned," *Kaiser Health News*, June 15, 2010.

[14] Kaiser Family Foundation Issue Brief, "Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011," February 2011.

The Medicare Advantage health plan star ratings are based on 36 measures of quality drawn from Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), the Medicare Health Outcomes Survey, and Centers for Medicare & Medicaid Services (CMS) Administrative Data (including measures like how many complaints were received about a plan).[15] The measures cover five broad areas:

- Staying healthy
- Managing chronic conditions
- Health plan responsiveness and care
- Member complaints and appeals
- Telephone customer service

Summary scores for each area are calculated by pooling individual scores (which can be clicked on by consumers who wish to dig deeper into the summary ratings). In assigning stars, some measures are "graded on a curve," while others are benchmarked against thresholds.[16] (See Appendix C for a complete listing of measures.)

Even CMS experts admit that most consumers choose plans based on price and providers, rather than on quality stars, with only a quarter of current enrollees choosing plans with four or more stars.[17]

Federal Quality Measurement Efforts for Children's Health Programs

The reauthorization of the Children's Health Insurance Program (CHIP), called CHIPRA, included a directive to develop a "core set of children's health quality measures for voluntary use by Medicaid and CHIP programs."[18] Taken together, these measures are intended to paint a picture of quality for children's health care. Criteria for the measures include that they: come from existing sources and be evidence-based; span the full range of care services, quality domains and providers; cover children of all ages; be understandable to consumers; and allow for identification of disparities—not only by race and ethnicity, but by socioeconomic status and special health care needs.[19] A national advisory committee developed some 24 initial core measures that are intended to be further improved over time. The core measures highlight five areas:

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[15] *See* http://www.medicare.gov; Kaiser Family Foundation, "Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011" February 2011.
[16] Kaiser Family Foundation, "Reaching for the Stars: Quality Ratings of Medicare Advantage Plans, 2011," February 2011.
[17] Ibid.
[18] *See* http://www.ahrq.gov/chipra/.
[19] Ibid.

- Prevention and health promotion
- Management of acute conditions
- Management of chronic conditions
- Family experiences of care
- Availability of care

Although the HEDIS measure for follow-up after hospitalization for mental illness is included in the set, a report on the national advisory committee's work admitted difficulty in including measures that would meet the above criteria in the mental health and substance abuse area, leaving an "empty chair" for these and other areas of care with few or no valid/feasible measures.[20] (See Appendix D for a complete list of core measures, and those which have been selected by HHS for an initial focus for outreach and technical assistance.)

Initial Set of Core Medicaid Measures

The ACA mirrors the CHIPRA requirement for Medicaid, calling for development of a "core quality set of measures" for Medicaid-eligible adults. An initial set of 51 measures, covering the same basic CHIPRA categories bulleted above, were chosen based on scientific acceptability, feasibility, and their importance to Medicaid programs. Working groups prioritized measures by the needs of the Medicaid population, including: maternal/reproductive health, overall adult health, complex health care needs, and mental health/substance abuse. In this set, following the priorities outlined above, proposed Mental Health and Substance Abuse measures are more expansive, including measures from the RAND Corporation such as use of screening, brief intervention, and referral for treatment for alcohol misuse, screening for depression and follow-up, along with a series of bipolar- and schizophrenia-related measures. While recognizing the importance of needing metrics for these "difficult to measure" areas, some Medicaid plans have expressed concerns about those proposed measures that are not more broadly used.[21] As with the children's measures, the intent is to improve these measures over time. (See Appendix E for the initial core set of measures.)

NCQA Accreditation and Report Cards

The ACA intends for qualified health plans to be accredited, and, as mentioned above, some suggest that HHS quality ratings might not stray far from accreditation standards like those currently used by the National Committee for Quality Assurance (NCQA). More than 100 million

[20] Mangione-Smith R. "Lessons Learned From the Process Used to Identify an Initial Core Quality Measure Set for Children's Health Care in Medicaid and CHIP," AHRQ, May 2010.
[21] Medicaid Health Plans of America, March 1, 2011, comment letter.

Americans are currently enrolled in NCQA-accredited health plans.[22] Based on compliance with a number of quality-related systems and processes, along with HEDIS/CAHPS scores, plans can earn ratings along a continuum from "denied" to "excellent." In reviewing plan processes and systems, NCQA teams look at areas of quality management and improvement, utilization management, credentialing and recredentialing, members' rights and responsibilities, standards for member connections, and Medicaid benefits and services.

Based on accreditation information and HEDIS/CAHPS measures, NCQA also develops report cards on accredited plans that assign star ratings (up to four stars) for five categories: 1) access/service, 2) qualified providers, 3) staying healthy, 4) getting better and 5) living with illness. To calculate a plan's stars, NCQA separates accreditation scores and HEDIS scores into the above categories and then compares actual earned scores with the total possible scores. Managed care plans, for example, that receive a score of 90% or more earn four stars.

Results From a Review of National and State Report Cards

Some 70 state and national websites—including NCQA's and New Jersey's—were examined as part of a recent AARP/Informed Patient Institute (IPI) report aimed at reviewing the state of the art in online plan report cards to help with thinking about quality information in the context of exchanges.[23]

Overall, more than half of the IPI-reviewed report cards use HEDIS measures (53%), with some drawing on individual scores, some using roll-up scores (averaging a series of individual measures in a given area into a single score), and some combining both. According to the report, the most commonly used measures were those indicating whether recommended care procedures, such as screenings, were received. Over half of the sites also use CAHPS data (often combined with HEDIS data), with the most common measures including overall plan ratings, getting care quickly, getting needed care, and how well doctors communicate. Some of the state report card sites also include information related to consumer complaints, either as reported to states or plans. [24]

Some of these sites track to benchmarks (like national or state averages), while others use best-performing plans (90th percentile) to assign ratings. Others track performance over time, using arrows to designate improvement or deterioration compared to prior years.[25]

In organizing plan information, some sites base it on broad care categories (prevention/staying well), while others use specific diseases or conditions (diabetes) or sort by types of measures (satisfaction).[26]

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[22] NCQA.
[23] Cronin C. "State Health Insurance Exchange Websites: A Review, Discussion and Recommendations for Providing Consumers Information about Quality and Performance," AARP, July 2011.
[24] Ibid.
[25] Ibid.

Consumers Union's report card (done in partnership with NCQA) uses a 100-point system with prevention and treatment accounting for 60% of scores; satisfaction accounting for 25% of scores; and accreditation accounting for 15%.

Now approaching its 15th year, the New Jersey HMO Report Card uses select HEDIS measures for staying healthy, respiratory conditions, and getting better/living with illness—combining measures collected by HMOs with measures from consumer surveys.[27] The report card compares commercial plan scores with state averages, as well as provides average plan use for sometimes overused procedures, a relatively unique feature among the sites reviewed by IPI. All commercial plans with a threshold level of participants are required to provide information for the report card measures.

New Jersey's Hospital Performance Report also provides online information to allow consumers to search for and compare quality care in New Jersey hospitals by hospital, county, or medical condition (http://web.doh.state.nj.us/apps2/hpr/index.aspx). Consumers can find information about hospitals' use of recommended treatment for heart attack, pneumonia, surgical care infection prevention, and heart failure. In addition, reports and data tables are available to compare mortality indicators and health care-associated infection rates for hospitals.

State Health Exchanges and Quality Measures

As states work toward having health care exchange programs operational by 2014, some states are further along than others in their exchange planning or early stages of implementation. What follows is a brief status report on several states' efforts to incorporate quality measures in health exchange ratings of plans.

Massachusetts Health Connector

The Massachusetts Health Connector presents quality ratings based on the NCQA health plan report card to help consumers in Commonwealth Choice with their plan selection.[28] After selecting preferences on overall benefit levels, consumers can compare plans based on NCQA report card information (with up to four stars assigned for overall ratings, access/service, qualified providers, staying healthy, getting better, and living with illness). Links are provided back to the NCQA site for additional information.

Since the Connector plans all have outstanding ratings, there is not too much differentiation in plan rankings and, at this writing, Connector staff were unable to track how

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[26] Ibid.
[27] Rutgers Center for State Health Policy helped analyze data related to these reports between 2004 and 2006.
[28] "Massachusetts Health Connector," The Commonwealth Fund, March 2011.

many site visitors actually viewed the full report card data.[29] As Massachusetts gears up for the rollout of Connector 2.0, they are awaiting federal guidance and then will pursue plans to revise their health plan quality ratings accordingly.[30]

California Health Benefit Exchange

The California Health Benefit Exchange has not had, as of yet, a robust discussion about quality measures planned for its exchange, focusing on more system design issues at this point.[31] An existing Office of the Patient Advocate site within the state includes star quality ratings for health plans based on HEDIS and CAHPS for common conditions and health concerns (asthma, diabetes, maternity care, lower-back pain). Indicators are summarized into overall scores, but consumers can access more information on individual measures and see how selected plans compare with the average scores for top performing plans in the nation.

Maryland Health Benefit Exchange

Maryland's report on implementation of its legislation requires the exchange to make recommendation to the governor and General Assembly on or before December 23, 2011, regarding "plan qualification, selection contracting, and quality ratings." Here too, staff indicates that they are also awaiting the next round of HHS guidance before marching too far along on development of quality ratings.[32]

Minnesota Health Insurance Exchange

As part of its own health reform in 2008, Minnesota adopted a core set of quality measures to be used throughout the state, including more value-based measures. A request for proposal for exchange IT development currently calls for incorporating cost/quality composite measures, along with 14 physician clinic quality measures and 50 hospital-based quality measures and information about whether or not providers are "health care homes" as key features in searching within the exchange for providers and plans.

New York Health Benefit Exchange

New York is also awaiting further guidance from HHS before moving forward with developing quality ratings. However, state staff believes that they can build on New York's current Quality Assurance Reporting Requirements (QARR) to develop exchange quality ratings. QARR includes a series of measures based largely on CAHPS and HEDIS, with specific measures added to

[29] Based on background expert interviews.
[30] Based on background expert interviews.
[31] Based on background expert interviews.
[32] Based on background expert interviews.

address health issues particularly important to the state. It is categorized by adults living with illness (preventive, acute, cardiac, respiratory, diabetes, medications), behavioral health, child and adolescent health, provider network, satisfaction, and women's health. Up or down arrows designate whether plan performance in these areas falls above or below state plan averages.

Oregon Health Insurance Exchange

In draft policy recommendations for its exchange, Oregon indicated plans to develop a "high value" designation to identify plans that meet higher quality and/or cost standards. The exchange however is currently focused on first-order priorities, like getting its staff and board in place.[33]

Wisconsin Office of Free Market Health Care Exchange Portal Prototype

Wisconsin's exchange prototype allows customers to shop based on ranking seven priorities, including:

- High overall quality
- High quality for conditions (listing common conditions, such as heart disease, diabetes, depression, etc.)
- Good customer service
- Inclusion of doctor
- Inclusion of regular hospital
- Low premiums
- Low out-of-pocket costs

It then provides information and overall grades (A, B, B+, etc.) on quality scores. While this feature is not available on the prototype at this point, it seems that consumers should eventually be able to access more information in order to better understand quality scores underlying the grades.[34]

Policy Considerations

There have been several recommendations for exchange quality information from policy experts.

In spring 2010 the National Academy of State Health Policy (NASHP) developed "aspects of reform states must get right if they are to be successful in their implementation" of reform.

[33] Based on background expert interviews.
[34] https://exchange.wisconsin.gov/exchange/.

These priorities call for states to "be strategic with health insurance exchanges," with an accompanying milestone to "adopt a plan rating system that meets or exceeds standards developed by the federal government." At the same time, NASHP recognizes, "Until guidance is issued, it is unclear how much discretion states may have in additional criteria."[35] In this guidance, HHS will need to balance its current "no one-size-fits-all approach" with repeated calls for standardization in measures, including those from national plans that would opt for consistent metrics from state to state.[36]

In addition, IPI outlines three separate decision points in considering plan quality metrics:

- What to present in the exchange portal as part of plan selection
- What information should be available through the exchange but outside of plan selection information
- What information should be presented by the plans outside of the exchange[37]

These decision points are very much in line with the organization of the ACA information requirements discussed earlier in this brief.

IPI also stresses the importance of engaging consumers in the development of the presentation of quality information to "ensure accessibility and understanding." According to NCQA, any consumer testing should be conducted "with real quality data."[38]

NCQA recently outlined a series of considerations on exchange quality ratings and decision support. The document suggests that wherever an exchange falls on the clearinghouse-to-selective purchaser continuum, it could adopt a system that would "nudge enrollees toward plans that offer the best value in terms of total cost and quality."[39]

In fact, in New Jersey's Health Insurance Exchange Stakeholder Forums, convened by the Rutgers Center for State Health Policy on behalf of the state, consumers viewed the exchange as having a key role in promoting information about quality and steering patients toward plans that promote quality. In specifically discussing plan information, consumer participants talked about the Medicare star model, but also raised the issue of posting both aggregate and individual plan consumer evaluations, with people being able to access other people's reviews of individual plans, including frustrations and criticisms. While some worry about the nonrepresentative and perhaps overly influential nature of these types of comments,

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[35] National Academy for State Health Policy, State Refor(u)m website, available at http://www.statereforum.org/.
[36] *See* www.healthcare.gov/news/factsheets/exchanges07112011.html; expert interview with New Jersey plan representative.
[37] Cronin C. "State Health Insurance Exchange Websites: A Review, Discussion and Recommendations for Providing Consumers Information about Quality and Performance," AARP, July 2011.
[38] NCQA "Exchange Quality Solutions: Ratings and Decision Support Tools." http://www.ncqa.org/tabid/1402/Default.aspx?q=Exchange+Quality+Solutions.
[39] Ibid.

the carriers themselves also expressed their own expectations about increased consumer blogging in moving forward.[40]

While acknowledging the difficulty in getting consumers engaged in plan quality measures generally, in a separate interview for this brief, one consumer expert expressed that it is important that whatever exchange quality ratings are selected be trustworthy, intuitive, easy to use, and include cognitive shortcuts, like stars.[41] If the portal gives every participating plan four stars, however, the system is hardly useful, the expert noted. The expert also spoke of network adequacy as likely being a key measure for the exchange to highlight for plans, featuring things like provider turnover rates. While acknowledging that *provider* quality ratings might ultimately rest with plans, rather than with the exchange, this same expert noted that the exchange could have a role in grading plans on how well they perform this function (of rating provider quality). This expert also spoke of the importance of proper and prominent placement of plan quality information even if consumers do not necessarily want it or ask for it in expressing their preferences for the exchange (though, as mentioned above, in New Jersey's forums, consumers did speak to its importance). As quality information is likely to be overshadowed by cost information in the decision process, some note the importance of placing quality metrics at multiple points in the portal. The IPI report, for example, suggests that consumers might find quality data more helpful if relevant measures were placed directly next to information explaining plan benefits for a particular area.[42]

Lastly, the exchange quality information presentation also needs to allow flexibility to be able to evolve over time based on consumer demand and preferences. The Massachusetts Connector, for example, now includes a feature to sort plans by provider, an enhancement that was just recently added to its Web portal.

Recommendations

Awaiting further guidance from the HHS Secretary on developing exchanges, at this point in time, states in the planning phase can take action on the following recommendations:

- *Consider how much leeway the guidance will allow.* While the amount of flexibility HHS will allow in developing the exchange plan ratings is unknown, it is unlikely that whatever guidance evolves would in any way limit flexibility in terms of additional quality information presented in the exchange outside the standard required ratings.

[40] March 15, 2011 Consumer Forum Notes; April 4, 2011 Carrier Forum Notes; and see "Talking Quality: Guidance for Sponsors of Consumer Reports on Health Care Quality," Agency for Health Care Research and Quality, available at https://www.talkingquality.ahrq.gov/default.aspx.
[41] Based on background expert interviews.
[42] Cronin C. "State Health Insurance Exchange Websites: A Review, Discussion and Recommendations for Providing Consumers Information About Quality and Performance," AARP, July 2011.

And, at least with respect to plan certification standards, HHS indicated that states may go well beyond the minimum.[43]

- *Segment the decision points.* As mentioned above, there are separate quality information decisions—1) what will be part of the portal decision tree; 2) what will be available through the exchange outside the decision process; and 3) what will be reported by the plans separately. Taken together, these points of information should provide consumers with the right level for smart decision-making and monitoring without being overwhelming.
- *Determine how active the exchange should be with respect to quality metrics.* The exchange could adopt NCQA's "nudging" model—either actively pointing consumers to higher quality plans or, like Medicare, flagging poorer-rated plans. Alternatively, it could just present the quality data without making recommendations.
- *Ensure consumer input.* Any quality information included in the exchange should be consumer-tested and approved. As mentioned above, the NCQA guide suggests testing with actual quality data.[44]
- *Link with state quality priorities.* Ideally, quality measures could not only help with consumer decision-making but feed into the state's broader agenda for health care quality improvement. If the HHS quality ratings do not include a measure that is an important one for the state, it could certainly be part of the portal elsewhere.
- *Build in flexibility*. Again, as mentioned above, the Massachusetts Connector initially was not built with a provider search link; this feature is now available. Building flexibility into search and selection criteria upfront will allow accommodation of such changes in exchange versions 2.0 and beyond.

[43] Volk J. "The Role of Exchanges in Quality Improvement: An Analysis of the Options," Georgetown University Health Policy Institute, September 2011.
[44] NCQA. "Exchange Quality Solutions: Ratings and Decision Support Tools." http://www.ncqa.org/tabid/1402/Default.aspx?q=Exchange+Quality+Solutions.

Appendix A: Excerpt From Initial Report on National Strategy for Quality Improvement in Health Care, March 2011[45]

The goals and illustrative measures described here are designed to begin a dialogue that will continue throughout 2011. The next version of the National Quality Strategy will reflect specific measures and include short-term and long-term goals. HHS will promote effective measurement while minimizing the burden of data collection by aligning measures across its programs, coordinating measurement with the private sector, and developing a plan to integrate reporting on quality measures with the reporting requirements for meaningful use of electronic health records (EHRs). All measures will be specifically assessed with the goal of making sure they can be included in electronic collection systems.

Priority	Initial Goals, Opportunities for Success, and Illustrative Measures
#1 **Safer Care**	**Goal:** Eliminate preventable health care-acquired conditions **Opportunities for success:** • Eliminate hospital-acquired infections • Reduce the number of serious adverse medication events **Illustrative measures:** • Standardized infection ratio for central line-associated blood stream infection as reported by CDC's National Healthcare Safety Network • Incidence of serious adverse medication events
#2 **Effective Care Coordination**	**Goal:** Create a delivery system that is less fragmented and more coordinated, where handoffs are clear, and patients and clinicians have the information they need to optimize the patient-clinician partnership **Opportunities for success:** • Reduce preventable hospital admissions and readmissions • Prevent and manage chronic illness and disability • Ensure secure information exchange to facilitate efficient care delivery **Illustrative measures:** • All-cause readmissions within 30 days of discharge • Percentage of providers who provide a summary record of care for transitions and referrals
#3 **Person- and Family-Centered Care**	**Goal:** Build a system that has the capacity to capture and act on patient-reported information, including preferences, desired outcomes, and experiences with health care **Opportunities for success:** • Integrate patient feedback on preferences, functional outcomes, and experiences of care into all care settings and care delivery • Increase use of EHRs that capture the voice of the patient by integrating patient-generated data in EHRs

[45] http://www.healthcare.gov/law/resources/reports/quality03212011a.html.

Priority	Initial Goals, Opportunities for Success, and Illustrative Measures
	• Routinely measure patient engagement and self-management, shared decision-making, and patient-reported outcomes **Illustrative measures:** • Percentage of patients asked for feedback
#4 **Prevention and Treatment of Leading Causes of Mortality**	**Goal:** Prevent and reduce the harm caused by cardiovascular disease **Opportunities for success:** • Increase blood pressure control in adults • Reduce high cholesterol levels in adults • Increase the use of aspirin to prevent cardiovascular disease • Decrease smoking among adults and adolescents **Illustrative measures:** • Percentage of patients ages 18 years and older with ischemic vascular disease whose most recent blood pressure during the measurement year is <140/90 mm Hg • Percentage of patients with ischemic vascular disease whose most recent low-density cholesterol is <100 • Percentage of patients with ischemic vascular disease who have documentation of use of aspirin or other antithrombotic during the 12-month measurement period • Percentage of patients who received evidence-based smoking cessation services (e.g., medications)
#5 **Supporting Better Health in Communities**	**Goal:** Support every U.S. community as it pursues its local health priorities **Opportunities for success:** • Increase the provision of clinical preventive services for children and adults • Increase the adoption of evidence-based interventions to improve health **Illustrative measures:** • Percentage of children and adults screened for depression and receiving a documented follow-up plan • Percentage of adults screened for risky alcohol use and if positive, received brief counseling • Percentage of children and adults who use the oral health care system each year • Proportion of U.S. population served by community water systems with optimally fluoridated water
#6 **Making Care More Affordable**	**Goal:** Identify and apply measures that can serve as effective indicators of progress in reducing costs **Opportunities for success:** • Build cost and resource use measurement into payment reforms • Establish common measures to assess the cost impacts of new programs and payment systems • Reduce amount of health care spending that goes to administrative

Priority	Initial Goals, Opportunities for Success, and Illustrative Measures
	burden • Make costs and quality more transparent to consumers **Illustrative measures:** • To be developed

Appendix B: National Quality Forum Care Coordination Measures

- Cardiac rehabilitation patient referral from an inpatient setting
- Cardiac rehabilitation patient referral from an outpatient setting
- Patients with a transient ischemic event ER visit who had a follow-up office visit
- Biopsy follow-up
- Reconciled medication list received by discharged patients (inpatient discharges to home/self care or any other site of care)
- Transition record with specified elements received by discharged patients (inpatient discharges to home/self-care or any other site of care)
- Timely transmission of transition record (inpatient discharges to home/self care or any other site of care)
- Transition record with specified elements received by discharged patients (emergency department discharges to ambulatory care [home/self care])
- Melanoma continuity of care–recall system
- 3-Item Care Transitions Measure (CTM-3)

Appendix C: Medicare Advantage Star Rating System Measures

Excerpted from Medicare.gov

Staying Healthy: Screenings, Tests and Vaccines	**Does the health plan do a good job detecting and preventing illness?** This category addresses how well each health plan works to detect and prevent illness, and improve or maintain physical and mental health. It includes whether health plan members get regular breast cancer screening with mammograms; regular screening for colon cancer and high cholesterol; vaccines for flu and pneumonia; and glaucoma and osteoporosis testing.
Breast Cancer Screening	Percent of female plan members aged 40-69 who had a mammogram during the past 2 years
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer
Cholesterol Screening for Patients with Heart Disease	Percent of plan members with heart disease who have had a test for “bad” (LDL) cholesterol within the past year
Cholesterol Screening for Patients with Diabetes	Percent of plan members with diabetes who have had a test for “bad” (LDL) cholesterol within the past year
Glaucoma Testing	Percent of senior plan members who got a glaucoma eye exam for early detection
Monitoring of Patients Taking Long-term Medications	Percent of plan members who got a 6 month (or longer) prescription for a drug known to have possibly harmful side effects among seniors if used long-term, and who had at least one appropriate follow-up visit during the year to monitor these medications: angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB), digoxin, diuretics, anticonvulsants, and statins.
Annual Flu Vaccine	Percent of plan members aged 65+ who got a vaccine (flu shot) prior to flu season
Pneumonia Vaccine	Percent of plan members aged 65+ who ever got a vaccine (shot) to prevent pneumonia
Improving or Maintaining Physical Health	Percent of all plan members whose physical health was the same or better than expected after two years
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years

Osteoporosis Testing	Percent of female, senior plan members who had a bone density test to check for osteoporosis (fragile bones)
Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year
At Least One Primary Care Doctor Visit in the Last Year	Percent of all plan members who saw their primary care doctor during the year
Managing Chronic (Long-Term) Conditions	**Does the health plan do a good job caring for people who have long-lasting or chronic conditions?** This category addresses how well each health plan helps people with chronic or long lasting health conditions. If you have a chronic health condition such as diabetes, high blood pressure, or arthritis, this information may be especially important to you. It includes whether people with diabetes are getting certain types of recommended care, whether people with high blood pressure are able to maintain a healthy blood pressure, whether people with bone fractures are tested for brittle bones, and whether people with arthritis are taking drugs to manage their condition.
Osteoporosis Management	Percent of female plan members who broke a bone and got screening or treatment for osteoporosis within 6 months
Eye Exam to Check for Damage From Diabetes	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year
Kidney Function Testing for Members With Diabetes	Percent of plan members with diabetes who had a kidney function test during the year
Plan Members With Diabetes Whose Blood Sugar Is Under Control	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.
Plan Members with Diabetes Whose Cholesterol Is Under Control	Percent of plan members with diabetes who had a cholesterol test during the year that showed an acceptable level of “bad” (LDL) cholesterol
Controlling Blood Pressure	Percent of plan members with high blood pressure who got treatment and were able to maintain a healthy pressure
Rheumatoid Arthritis Management	Percent of plan members with rheumatoid arthritis who got 1 or more prescription(s) for an anti-rheumatic drug
Testing to Confirm Chronic Obstructive Pulmonary Disorder	Percent of senior plan members with active chronic obstructive pulmonary disease who got appropriate spirometry testing to confirm the diagnosis.

Improving Bladder Control	Percent of members with a urine leakage problem who discussed the problem with their doctor and got treatment for it within 6 months
Reducing the Risk of Falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year
Ratings of Health Plan Responsiveness and Care	**Does the health plan provide timely information and care?** This category addresses how well each health plan responds when its members need information and care. It includes whether doctors take the time to carefully and clearly explain things to you, being able to get appointments and care quickly and easily, and being able to find information about the health plan when you need it. When comparing plans on this category, it's better to look at and compare star ratings than to compare plans using the number ratings. The star ratings are better because they capture more statistical information while keeping it easy to make comparisons.
Ease of Getting Needed Care and Seeing Specialists	Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists
Doctors Who Communicate Well	Percent of best possible score the plan earned on how well doctors communicate
Getting Appointments and Care Quickly	Percent of best possible score the plan earned on how quickly members get appointments and care
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed
Overall Rating of Health Care Quality	Percent of best possible score the plan earned from plan members who rated the overall health care received
Members' Overall Rating of Health Plan	Percent of best possible score the plan earned from plan members who rated the overall plan
Health Plan Member Complaints and Appeals	**This category shows how the health plan is doing in the following areas:** How quickly and how well each health plan handles appeals made by members. An appeal is a special kind of request you file if you disagree with a decision made by your health plan about what care the plan will cover or how much it will pay. As an extra protection for members, sometimes an outside panel of experts is asked to review the decisions made by health plans. This category tells how quickly the plan handles appeals and whether the health plan's decisions are upheld by outside experts. How many complaints, for every 1,000 members, Medicare got about each health plan from its members. Problems Medicare found when it has done audits to check beneficiary access.
Complaints About the Health Plan	How many complaints Medicare received about the health plan

Health Plan Makes Timely Decisions About Appeals	Percent of plan members who got a timely response when they made a written appeal to the health plan about a decision to refuse payment or coverage
Fairness of Health Plan's Denials to a Member's Appeal, Based on an Independent Reviewer	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal
Beneficiary Access Problems Medicare Found During an Audit of the Plan (more stars are better because they mean fewer serious problems)	Medicare oversees the operations of health plans by auditing. Some plans are selected at random for an audit. Other plans are audited because Medicare thinks there could be a problem. Not every plan is audited every year, so "not audited" is neither good nor bad. Medicare gives the plan a rating from 0 to 100 for beneficiary access problems found during an audit. The rating combines **how severe the** problems were, **how many** there were, and **how much** they affect plan members directly.
Health Plan's Telephone Customer Service	**This rating shows how the health plan performs in the following customer service areas:** How long members wait on hold when they call the health plan's customer call center How often the plan's representative gives accurate information How often TTY/TDD services and foreign language interpretation are available for members
Time on Hold When Customer Calls Health Plan	How long members wait on hold when they call the health plan's customer service number.
Accuracy of Information Members Get When They Call the Health Plan	Percent of the time members are given correct information by the health plan's customer service representative
Availability of TTY/TDD Services and Foreign Language Interpretation When Members Call the Health Plan	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number

Appendix D: CHIPRA Initial Core Quality Indicators

From AHRQ Website, With Priority Measures Bolded

Measure Number	LEGISLATIVE MEASURE TOPIC/Subtopic/Current Measure Label	Current Measure Steward
PREVENTION AND HEALTH PROMOTION		
Prenatal/Perinatal		
1	Frequency of ongoing prenatal care	NCQA
2	Timeliness of prenatal care—the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization	NCQA
3	Percent of live births weighing less than 2,500 grams	NVSS
4	Cesarean rate for nulliparous singleton vertex	CMQC
Immunizations		
5	**Childhood immunization status**	NCQA
6	Immunizations for adolescents	NCQA
Screening		
7	**Weight assessment for children/adolescents**	NCQA
8	Screening using standardized screening tools for potential delays in social and emotional development	None
9	**Chlamydia screening for women**	NCQA
Well-child Care Visits (WCV)		
10	**WCVs in the first 15 months of life**	NCQA
11	**WCVs in the third, fourth, fifth and sixth years of life**	NCQA
12	WCV for 12-21 yrs of age—with PCP or OB-GYN	NCQA

Dental		
13	**Total eligibles receiving preventive dental services**	States/CMS
MANAGEMENT OF ACUTE CONDITIONS		
Upper Respiratory—Appropriate Use of Antibiotics		
14	**Pharyngitis—appropriate testing related to antibiotic dispensing**	NCQA
15	Otitis Media with Effusion—avoidance of inappropriate use of systemic antimicrobials—ages 2-12	AMA PCPI
Dental		
16	**Total EPSDT eligibles who received dental treatment services (EPSDT CMS Form 416, Line 12C)**	States/CMS
Emergency Department		
17	Emergency Department (ED) Utilization—Average number of ED visits per member per reporting period	S/ME
Inpatient Safety		
18	**Pediatric catheter-associated blood stream infection rates (PICU and NICU)**	Hospitals/CDC
MANAGEMENT OF CHRONIC CONDITIONS		
Asthma		
19	**Annual number of asthma patients (≥1 year old) with ≥1 asthma related ER visit (S/AL Medicaid Program)**	S/AL
ADHD		
20	Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (Continuation and Maintenance Phase)	NCQA
Mental Health		
21	Follow up after hospitalization for mental illness	NCQA
Diabetes		
22	**Annual hemoglobin A1C testing (all children and adolescents diagnosed with diabetes)**	S/AL
FAMILY EXPERIENCES OF CARE		
23	**HEDIS CAHPS® 4.0 instruments including supplements for children with chronic conditions and Medicaid plans**	NCQA
AVAILABILITY		
24	**Children and adolescents' access to primary care practitioners (PCP),**	NCQA

Appendix E: Core Medicaid Measures

From December 30, 2010, Federal Register

Number	NQF ID†	Measure owner	Measure name	EHR‡
			Prevention & Health Promotion	
1	0039	NCQA	Flu Shots for Adults Ages 50–64 (Collected as part of HEDIS CAHPS Supplemental Survey).	
2	0421	CMS	Adult Weight Screening and Follow up	X
3	0031	NCQA	Breast Cancer Screening	X
4	0032	NCQA	Cervical Cancer Screening	X
5	NA	RAND	Alcohol Misuse: Screening, Brief Intervention, Referral for Treatment	
6	0027	NCQA	Medical Assistance With Smoking and Tobacco Use Cessation	X
7	0418	CMS	Screening for Clinical Depression and Followup Plan	
8	NA	NCQA	Plan All-Cause Readmission.	
9	0272	AHRQ	PQI 01: Diabetes, short-term complications	
10	0273	AHRQ	PQI 02: Perforated appendicitis.	
11	0274	AHRQ	PQI 03: Diabetes, long-term complications	
12	0275	AHRQ	PQI 05: Chronic obstructive pulmonary disease	
13	0276	AHRQ	PQI 07: Hypertension.	
14	0277	AHRQ	PQI 08: Congestive heart failure.	
15	0280	AHRQ	PQI 10: Dehydration	
16	0279	AHRQ	PQI 11: Bacterial pneumonia	
17	0281	AHRQ	PQI 12: Urinary Tract Infection Admission Rate	
18	0282	AHRQ	PQI 13: Angina without procedure.	
19	0638	AHRQ	PQI 14: Uncontrolled Diabetes Admission Rate	
20	0283	AHRQ	PQI 15: Adult asthma.	
21	0285	AHRQ	PQI 16: Lower extremity amputations among patients with diabetes	
			Management of Acute Conditions	
22	0052	NCQA	Use of Imaging Studies for Low Back Pain	X
23	0640	TJC	HBIPS—2 Hours of physical restraint use.	
24	0576	NCQA	Followup After Hospitalization for Mental Illness	
25	0476	Providence St. Vincent Medical Center.	Appropriate Use of Antenatal Steroids.	
26	0469	Hospital Corporation of America	Elective delivery prior to 39 completed weeks gestation	
27	0648	AMA–PCPI	Timely Transmission of Transition Record (Inpatient Discharges to Home/Self-Care or Any Other Site of Care).	
28	0647	AMA–PCPI	Transition Record With Specified Elements Received by Discharged Patients (Inpatient Discharges to Home/Self-Care or Any Other Site of Care).	
			Management of Chronic Conditions	
29	0071	NCQA	Persistence of Beta-Blocker Treatment After a Heart Attack	
30	0018	NCQA	Controlling High Blood Pressure	X
31	0074	AMA–PCPI	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL Cholesterol.	X
32	0075	NCQA	Comprehensive Ischemic Vascular Disease Care: Complete Lipid Profile and LDL–C Control Rates.	X
33	0063	NCQA	Diabetes: Lipid profile.	
34	0057	NCQA	Comprehensive Diabetes Care: Hemoglobin A1c testing	
35	0036	NCQA	Use of Appropriate Medications for People With Asthma	X
36	0403	NCQA	HIV/AIDS: Medical visit.	
37	0105	NCQA	Antidepressant Medication Management	X
38	NA	RAND	Bipolar I Disorder 2: Annual assessment of weight or BMI, glycemic control, and lipids.	
39	NA	RAND	Bipolar I Disorder C: Proportion of patients with bipolar I disorder treated with mood stabilizer medications during the course of bipolar I disorder treatment.	
40	NA	RAND	Schizophrenia 2: Annual assessment of weight/BMI, glycemic control, lipids.	
41	NA	RAND	Schizophrenia B: Proportion of schizophrenia patients with long-term utilization of antipsychotic medications.	
42	NA	RAND	Schizophrenia C: Proportion of selected schizophrenia patients with antipsychotic polypharmacy utilization.	
43	0021	NCQA	Annual Monitoring for Patients on Persistent Medications	
44	0541	PQA	Proportion of Days Covered (PDC): 5 Rates by Therapeutic Category	
			Family Experiences of Care	
45	0006	AHRQ	CAHPS Health Plan Survey v 4.0—Adult Questionnaire	
46	0007	NCQA	CAHPS Health Plan Survey v 4.0H—NCQA Supplemental items for CAHPS 4.0 Adult Questionnaire.	
			Availability	
47	NA	NCQA	Ambulatory Care: Outpatient and Emergency Department Visits	
48	NA	NCQA	Inpatient Utilization: General Hospital/Acute Care	
49	0004	NCQA	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.	X
50	NA	NCQA	Mental Health Utilization.	
51	NA	NCQA	Prenatal and Postpartum Care: Postpartum Care Rate	

† NQF ID National Quality Forum identification numbers are used for measures that are NQF-endorsed; otherwise, NA is used.
‡ EHR Measures with an "X" are included in the Medicare and Medicaid Electronic Health Record Incentive Payment Program and may be collected through electronic health records. Specifications for these measures are available from the Centers for Medicare & Medicaid Services Web site at: *http://www.cms.gov/QualityMeasures/03_ElectronicSpecifications.asp#TopOfPage.*

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RUTGERS

Center for State Health Policy

Center for State Health Policy
Rutgers, The State University of New Jersey
112 Paterson Street, 5th Floor
New Brunswick, NJ 08901

p. 848-932-3105 f. 732-932-0069
cshp_info@ifh.rutgers.edu
www.cshp.rutgers.edu